UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

PAULETTE ARDOLINO,
Plaintiff,

v. CIVIL ACTION NO. 00-12115-DPW

METROPOLITAN LIFE INSURANCE COMPANY
and TUFTS UNIVERSITY,
Defendants.

MEMORANDUM AND ORDER RE: PLAINTIFF'S MOTION TO COMPEL DEFENDANT, METROPOLITAN LIFE INSURANCE COMPANY, TO ANSWER THE PLAINTIFF'S INTERROGATORIES AND PLAINTIFF'S REQUEST FOR PRODUCTION OF DOCUMENTS PURSUANT TO FED.R.CIV.P. 37 (DOCKET ENTRY # 17)

July 2, 2001

BOWLER, U.S.M.J.

Plaintiff Paulette Ardolino ("plaintiff") moves to compel defendant Metropolitan Life Insurance Company ("MetLife") to answer interrogatories and respond to a request for production of documents. (Docket Entry # 17). Plaintiff also moves for expenses and attorney's fees under Rule 37(a)(4), Fed. R. Civ. P. MetLife opposes the motion. (Docket Entry 19). After conducting a hearing on June 25, 2001, this court took the motion to compel (Docket Entry # 17) under advisement.

BACKGROUND[1]

Defendant Tufts University maintains a group longterm disability plan ("the plan") for its eligible employees. Plaintiff, an allegedly eligible employee within the meaning of the plan, began her employment at Tufts in September 1987. Ten years later in December 1997, she applied for disability benefits on the basis of a primary diagnosis of fibromyalgia and secondary diagnosis of chronic fatigue syndrome. MetLife initially denied plaintiff disability benefits and plaintiff appealed. Thereafter, MetLife reversed its decision and awarded plaintiff disability benefits for the closed-end period of March 22, 1998 to August 31, 1998. It also requested additional medical documentation to continue payment of disability benefits beyond August 31, 1998.

The parties dispute whether plaintiff complied with the request for additional documentation. On May 19, 2000, MetLife issued a final decision denying disability benefits for the period after August 31, 1998. As set forth in the denial letter, the plan defines "disability" as requiring "'the regular care and attendance of a Doctor'" and being unable to perform the material

[1] Background facts are taken from admissions contained in the answers to the complaint (Docket Entry ## 5 & 6) as well as documents attached to the motion to compel and the opposition (Docket Entry ## 17 & 19).

duties of the employee's regular job.[2] The plan cautions that disability benefits will be paid if the employee remains disabled "'and proof of disability is submitted, at your expense, to us upon request.'" (Docket Entry # 19, Ex. A). According to the denial letter, MetLife denied benefits after August 31, 1998, because plaintiff "was not under the regular care and attendance of a doctor and, clearly, proof of continued disability [had] not been submitted; despite several requests . . .." (Docket Entry # 19, Ex. A).

Plaintiff filed suit under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. Citing section 1132(a)(1)(B),[3] plaintiff claims that MetLife arbitrarily and capriciously denied her disability benefits under the terms of the plan. At the hearing and in the motion papers, the parties concur that an arbitrary and capricious standard of

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[2] After 24 months of benefit payments, the plan also requires the employee to be unable to perform material duties of any gainful work or service. This provision, which more closely tracks a disability determination by the Social Security Administration, was not triggered in plaintiff's case because she only received benefits for approximately five months.

[3] This section of ERISA gives a plan beneficiary the right to "bring a civil action 'to recover benefits due' under the plan or to enforce 'rights' under the plan." Doe v. Travelers Insurance Company, 167 F.3d 53, 56 (1st Cir. 1999). The complaint also cites 29 U.S.C. § 1132(c). This section gives the court discretion to render the administrator personally liable to the participant or beneficiary in the event the administrator fails to comply with 29 U.S.C. § 1166(1) or (4) or 29 U.S.C. § 1021(e)(1) or the administrator fails to comply with a request for information which he is required to furnish to the participant or beneficiary. 29 U.S.C. § 1132(c).

review applies to MetLife's decision to deny benefits.[4]

DISCUSSION

MetLife did not completely fail to answer the interrogatories or requests for documents. Rather, MetLife objected to producing the information because it was contained in the claims file. To the extent the requested information was not in the claims file, MetLife objected to producing the information because review under the arbitrary and capricious standard is limited to the claims file. Absent good cause, discovery is limited to information relevant to "the claim or defense of any party."[5] Rule 26(b)(1), Fed. R. Civ. P.

Where, as here, review is under the more deferential arbitrary and capricious standard,[6] "district courts may consider

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[4] The plan is not contained in the record. Hence, this court cannot evaluate whether the plan's language gives the administrator or fiduciary the necessary discretion thereby triggering the arbitrary and capricious standard of review.

[5] In the supporting memorandum (Docket Entry # 18, p. 3), plaintiff incorrectly relies on the earlier and broader version of Rule 26(b)(1), Fed. R. Civ. P.

[6] Where the administrator has discretion under the terms of a plan, his "decision must be upheld unless 'arbitrary, capricious, or an abuse of discretion.'" Doyle v. Paul Revere Life Insurance Company, 144 F.3d 181, 183 (1st Cir. 1998). Under this deferential standard of review, the administrator's decision is upheld if it was in the administrator's "authority, reasoned, and 'supported by substantial evidence in the record.'" Doyle v. Paul Revere Life Insurance Company, 144 F.3d at 184. Substantial evidence "means evidence reasonably sufficient to support a conclusion." Doyle v. Paul Revere Life Insurance Company, 144 F.3d at 184.

only the evidence that the fiduciaries themselves considered." Miller v. United Welfare Fund, 72 F.3d 1066, 1071 (2d Cir. 1995). Although the First Circuit has left the question open, see Doe v. Travelers Insurance Company, 167 F.3d 53, 58 n. 3 (1st Cir. 1999) (assuming review was limited for purpose of affirming lower court's finding that insurer acted unreasonably in denying benefits), the majority of circuits limit arbitrary and capricious review to the information before the administrator. See Miller v. United Welfare Fund, 72 F.3d at 1071 (collecting cases from third, sixth, eighth, ninth and tenth circuits; see also Perlman v. Swiss Bank Corporation, 195 F.3d 975, 982 (7th Cir. 2000) (agreeing with majority of circuits that review is limited to information submitted to administrator under arbitrary and capricious standard); Quesinberry v. Life Insurance Company of North America, 987 F.2d 1017, 1021-1027 (4th Cir. 1993) (distinguishing Berry v. Ciba-Geigy Corporation, 761 F.2d 1003, 1006-1107 (4th Cir. 1985)).

Even assuming that the First Circuit would follow the majority view,[7] however, the fact that review on the merits is limited to the administrative record does not preclude certain discovery "'to determine the actual parameters of the administrative record and whether or not the fiduciary acted arbitrarily and capriciously with respect to a particular claim

[7] The Fifth Circuit allows a broader scope of review. Wildbur v. ARCO Chemical Company, 974 F.2d 631, 638 & 642 (5th Cir. 1992).

for benefits." Nagele v. Electronic Data Systems Corporation, 193 F.R.D. 94, 103 (W.D.N.Y. 2000). Likewise, the court in Caldwell v. Life Insurance Company of North America, 165 F.R.D. 633, 637 (D.Kan. 1996), allowed the plaintiff limited discovery "to determine whether the fiduciary or administrator fulfilled his fiduciary role in obtaining the necessary information in order to make his determination, whether the persons who assisted in compiling the record followed the proper procedure, as well as, whether the record is complete.'"

This court's reasoning is threefold. First, it is appropriate to examine trust law although such law "'must give way if it is inconsistent with the language of [ERISA], its structure, or purpose.'" State Street Bank and Trust Company v. Denman Tire Corporation, 240 F.3d 83, 90 (1st Cir. 2001). Under such law, "discovery is available where a beneficiary challenges a trustee alleging improper administration of a trust for the beneficiary's benefit." Nagele v. Electronic Data Systems Corporation, 193 F.R.D. at 103.

Second, in dicta, the First Circuit described the "record" in an ERISA denial of benefits action as including, inter alia, "the recollections of oral conversations," which, in turn, "can require discovery and even fact finding by the district court." Doe v. Travelers Insurance Company, 167 F.3d at 58 (applying deferential review and therefore judging reasonableness of decision to deny benefits). Recollections of oral conversations are not necessarily in the administrative record. Consequently,

it is unlikely that the First Circuit would take the position of the Seventh Circuit in Perlman v. Swiss Bank Corporation, 195 F.3d at 982 (finding that mental processes of plan's administrator "are not legitimate grounds of inquiry").

Finally, as evidenced by the cases cited by the court in Nagele, discovery is not necessarily limited to the paper record before the plan administrator. See Nagele v. Electronic Data Systems Corporation, 193 F.R.D. at 104-105 (collecting examples of cases where courts used deposition testimony and interrogatory answers in conducting arbitrary and capricious standard of review).

Notwithstanding the foregoing, however, discovery in an ERISA case employing deferential review is not open-ended. "ERISA's goal of speedy adjudication," Nagele v. Electronic Data Systems Corporation, 193 F.R.D. at 105, coupled with the limitation of review on the merits to the record, operates to circumscribe discovery. For example, discovery related to new evidence outside the administrative record, such as newly uncovered medical opinions that the plaintiff was disabled, is improper. See Caldwell v. Life Insurance Company of North America, 165 F.R.D at 637. "'Plaintiff is not entitled to engage in discovery which could have or should have been presented to the administrator prior to action on the [ERISA] claim.'" Caldwell v. Life Insurance Company of North America, 165 F.R.D at 637. Furthermore, this court may limit and deny relevant discovery where it is "'unreasonably cumulative or duplicative,

or is obtainable from some other source that is more convenient, less burdensome and less expensive.'" Ameristar Jet Charter, Inc. v. Signal Composites, Inc., 244 F.3d 189, 193 (1st Cir. 2001) (quoting Rule 26(b)(2) and affirming lower court's restriction of relevant discovery).

With these parameters in mind, this court turns to the disputed interrogatories. MetLife is ordered to answer interrogatory numbers: one; two; three, to the extent the information is in the possession, control or custody of MetLife; four, limited to the time period prior to June 19, 2000;[8] five, limited to the evidence in MetLife's possession prior to June 19, 2000; six(a)-(d), inasmuch as the education and training of the individuals who reviewed plaintiff's claim may shed light on whether MetLife used individuals who completely lacked adequate training, see, e.g., Bedrick v. Travelers Insurance Company, 93 F.3d 149, 151-153 (4th Cir. 1996) (lack of experience in area of the disability at issue considered probative of whether claimant received full and fair review); six(e), limited to employee guidelines, manuals or training courses in effect from the date of plaintiff's initial application for benefits to May 19, 2000, see, e.g., Bedrick v. Travelers Insurance Company, 93 F.3d at 153 (noting that Travelers' "'significant progress'" reason for terminating benefits was not in "Travelers' internal guidelines"

[8] The additional month after the May 19, 2000 final denial letter allows for Metife's receipt of any information sent by plaintiff prior to her receipt of the denial letter.

thereby indicating such guidelines were subject to discovery); seven; eight(a)-(c) and (e) and nine(a)-(c) and (e); eight(d) and nine (d), limited to the period of 1998 to the date the particular physician last worked on plaintiff's case; ten, 11 and 12, limited to the time period prior to June 19, 2000; 13, limited to plaintiff's position as a staff assistant as stated in the final denial letter; 14, limited to the contention that plaintiff was not disabled as set forth in the final denial letter; 15, limited to the period when plaintiff became disabled on September 22, 1997 to August 31, 1998, as set forth in the September 28, 1999 letter (Docket Entry # 19, Ex. A); 16, limited to the time period prior to June 19, 2000; 17; 21; 22; and 23, limited to identifying the privilege and to describing the nature of the document "in a manner that, without revealing information itself privileged or protected, will enable" plaintiff "to assess the applicability of the privilege." Fed. R. Civ. P. 26(b)(5); see LR. 34.1(e) (requiring objecting party to identify the particular privilege claimed with respect to each withheld document).

As to interrogatory numbers 18 through 20, an award of disability benefits by the Social Security Administration does not have a binding effect on MetLife's decisions to discontinue benefits beyond August 31, 1998.[9] See Doyle v. Paul Revere Life

[9] In Count II, plaintiff alleges that "Defendant" required her to apply for Social Security benefits and is therefore "judicially estopped from disregarding or disputing the designation of the disabled status." (Docket Entry # 1, ¶¶ 19 &

Insurance Company, 144 F.3d at 187 n. 4; see also Chandler v. Raytheon Employees Disability Trust, 53 F.Supp.2d 84, 91 (D.Mass.), aff'd, 229 F.3d 1133 (1st Cir. 2000), cert. denied, __U.S.__, 121 S.Ct. 861 (2001). Moreover, the plan's definition of disability quoted in the final denial letter does not define the term "disabled" in reference to an award of benefits by the Social Security Administration. Cf. De Dios Cortes v. MetLife, Inc., 122 F.Supp.2d 121, 130-131 (D.P.R. 2000) (Social Security disability award "highly material" inasmuch as plan defined "total disability in part by reference to an award of benefits by the Social Security Administration"). Accordingly, MetLife need not answer interrogatory numbers 18 and 19. MetLife is ordered to answer interrogatory number 20, limited to the definition of disability used in the plan in effect at the time of the September 29, 1999 and May 19, 2000 denials of plaintiff's claim beyond August 31, 1998.

Addressing the disputed document requests, MetLife's answer to document request numbers one, four, five, six, seven and eight are sufficient. As to document request numbers two and three, MetLife's definition of "relevant" may be overly restricted. It is therefore directed to review its answers to document request numbers two and three in light of this court's discussion regarding the scope of discovery and to supplement its responses,

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21). Even discounting the questionable merits of the allegations as a substantive basis for relief, this court doubts the viability of Count II as a separate cause of action in light of ERISA's preemptive effect.

if necessary. MetLife is ordered to provide the materials requested in document request number nine, limited to the disability examiner/adjuster[10] who reviewed plaintiff's claim and the time period of 1998 to the date the disability examiner/adjuster last worked on plaintiff's case. Document request number ten is denied as unreasonably cumulative and duplicative of interrogatory numbers eight and nine.

CONCLUSION

Plaintiff's motion to compel (Docket Entry # 17) is **ALLOWED** in part and **DENIED** in part to the extent set forth in this opinion. Plaintiff's request therein for expenses and attorney's fees is **DENIED**. MetLife shall provide amended answers to the interrogatories and document requests on or before July 23, 2001.

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MARIANNE B. BOWLER
United States Magistrate Judge

[10] The document request for the examiner/adjuster is phrased in the singular.

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U.S. District Court - Massachusetts (Boston)

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